JEFFERSON COUNTY HEALTH DEPARTMENT-VACCINE(S) ADMINISTRATION FORM

The purpose of this form is to document authorization to vaccinate. Information may be shared with other health care providers directly involved with the client to insure a complete vaccine schedule. I have been given a copy of the HIPAA notice of privacy practices and VIS form and have read, or have had explained to me, information about the disease(s) and vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the requested vaccines and ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make that request. If applicable, I authorize the Jefferson County Health Department to bill and receive direct payment from Medical Assistance for services received at the Health Department.

___DTaP ___Hib ___Hep B ___IPV ___Rota ___PCV13 ____MMR ___Var ___Hep A ___Td ___Tdap ___HPV ___Meningo ___Infl ___PPV

For internet access to records, provide **SS#** _____ **Medicare/BadgerCare #**_____

Circle one: Insurance w/ vaccine coverage Insurance w/o vaccine coverage No insurance Badger Care Native American Medicare

Name__ _____ ___ _____ _____ **DOB** _____ **Age**_____ **Male / Female**
Last **First** **Mid. Initial**

Address _____ **City** _____ **State** _____ **County** _____ **Zip**_____

Telephone (_____)_____ **Mother's Maiden Name** _____ **Physician** _____

(Circle one) Race: African American Asian Pacific Islander Caucasian Native American **Ethnicity:** Hispanic Non Hispanic

1. Does the person receiving vaccines have allergies to any foods or medications? **Yes No** If yes, explain_____
2. Has the person receiving vaccines ever had a bad reaction to vaccines in the past? **Yes No** If yes, explain_____
3. Has the person receiving vaccines had any signs of illness in the past 24 hours? **Yes No** If yes, explain_____
4. Does the person receiving vaccines have any medical conditions (asthma, seizures)? **Yes No** If yes, explain_____
5. Has the person receiving vaccines had any other vaccines in the past 4 weeks? **Yes No** If yes, explain_____
6. Is there any chance that the person receiving vaccines is pregnant? **Yes No**

Signature _____ **Print Name** _____ self parent guardian **Date** _____

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VACCINE	ROUTE	SITE	DOSE	MAN/EXP	LOT #	SIGN/TITLE	VIS
DTaP	IM	RV LV RD LD	1 2 3 4 5 P K				5/17/07 10/22/14
IPV	IM	RV LV RD LD	1 2 3 4 P K				11/8/11 10/22/14
HIB	IM	RV LV RD LD	1 2 3 4 P				4/2/15 10/22/14
HEP A	IM	RV LV RD LD	1 2 3 T				10/25/11
HEP B	IM	RV LV RD LD	1 2 3 4 T P				2/2/12 10/22/14
ROTAVIRUS	PO		1 2 3				4/15/15
MMR	SC	RV LV RD LD	1 2				4/20/12
VARICELLA	SC	RV LV RD LD	1 2				3/13/08
PCV13	IM	RV LV RD LD	1 2 3 4 5				2/27/13 10/22/14
Td/Tdap	IM	RV LV RD LD	1 2 3				2/24/15
MENINGO	IM	RV LV RD LD	1 2				10/14/11
HPV	IM	RV LV RD LD	1 2 3				3/31/16
Influenza	IM Nasal	RV LV RD LD	1 2				8/7/15

R/L = right/left V = vastus lateralis D = deltoid P = Pediarix (DTaP + IPV + Hep B) or Pentacel (DTaP + Hib + IPV) T = Twinrix (Hep A + B) K = Kinrix (DTaP + IVP)

Date Administered: _____ **Date VIS given:** _____ ☐ HIPAA Notice of Privacy Practices

COMMENTS: